HEALTH INSURANCE CLAIM FORM - HCFA-1500 2010.1

2010. PURPOSE OF HEALTH INSURANCE CLAIM FORM - HCFA-1500

The HCFA-1500 answers the needs of many health insurers. It is the basic form prescribed by HCFA for the Medicare program for claims from physicians and suppliers, except for ambulance services. It has also been adopted by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and has received the approval of the American Medical Association (AMA) Council on Medical Services.

Use these instructions for completing this form. The HCFA-1500 has space for physicians and suppliers to provide information on other health insurance. Use this information to determine whether the Medicare patient has other coverage which must be billed prior to Medicare payment, or whether there is a Medigap policy under which payments are made to a participating physician or supplier.

2010.1 Items 1-13 - Patient and Insured Information. --

Item 1. Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

Item 1a.Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer.

Item 2. Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card.

Item 3. Enter the patient's eight-digit birth date (MMDDCCYY) and sex.

Item 4. If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Item 5. Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Item 6. Check the appropriate box for patient's relationship to insured when item 4 is completed.

Item 7. Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4 & 11 are completed.

Item 8. Check the appropriate box for the patient's marital status and whether employed or a

student.

Item 9. Enter the last name, first name, and middle initial of the enrollee in a Medigap policy, if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. This field may be used in the future for supplemental insurance plans.

NOTE: ONLY PARTICIPATING PHYSICIANS AND SUPPLIERS ARE TO COMPLETE ITEM 9 AND ITS SUBDIVISIONS, AND ONLY WHEN THE BENEFICIARY WISHES TO ASSIGN HIS/HER BENEFITS UNDER A MEDIGAP POLICY TO THE PARTICIPATING PHYSICIAN OR SUPPLIER.

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.

Medigap.--A Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in º1882(g)(1) of Title XVIII of the Social Security Act and the definition contained in the NAIC Model Regulation which is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

Item 9a. Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.

NOTE: Item 9d must be completed if you enter a policy and/or group number in Item 9a.

Item 9b. Enter the Medigap insured's eight-digit birth date (MMDDCCYY) and sex.

Item 9c. Leave blank if a Medigap PayerID is entered in item 9d. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two letter postal code, and zip code copied from the Medigap insured's Medigap identification card. For example:

1257 Anywhere Street
Baltimore, MD 21204

is shown as "1257 Anywhere St MD 21204."

Item 9d. Enter the nine-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then enter the Medigap insurance program or plan name.

If you are a participating provider of service or supplier and the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, all of the information in items 9, 9a, 9b, and 9d must be complete and accurate. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

Items 10a thru 10c. Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

Item 10d. Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.

Item 11. THIS ITEM MUST BE COMPLETED. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c.

NOTE: Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11.

If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g. - insured retired), enter the word "NONE" and proceed to item 11b.

Insurance Primary to Medicare.--Circumstances under which Medicare payment may be secondary to other insurance include:

- o Group Health Plan Coverage:
  - -- Working Aged;
  - -- Disability --(Large Group Health Plan); and
  - -- End Stage Renal Disease.
- o No Fault and/or Other Liability:
- o Work-Related Illness/Injury:
  - -- Workers' Compensation;
  - -- Black Lung; and
  - -- Veterans Benefits.

NOTE: For a paper claim to be considered for Medicare Secondary Payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.

Item 11a.Enter the insured's eight-digit birth date (MMDDCCYY) and sex if different from item 3.

Item 11b. Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter the eight-digit retirement date (MMDDCCYY) preceded by the word "RETIRED."

Item 11c. Enter the nine-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the complete primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB.

Item 11d. Leave blank. Not required by Medicare.

Item 12. The patient or authorized representative must sign and enter the eight-digit date (MMDDCCYY) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with ºº3047.1 - 3047.3. If the patient is physically or mentally unable to sign, a representative specified in º3008 may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless patient or the patient's representative revokes this arrangement.

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X). When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Item 13. The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item, or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

2010.2 Items 14-33 - Provider of Service or Supplier Information. --

Item 14. Enter eight-digit date (MMDDCCYY) of current illness, injury, or pregnancy. For chiropractic services, enter the eight-digit date (MMDDCCYY) of the initiation of the course of treatment and enter the eight-digit X-ray date (MMDDCCYY) in item 19.

Item 15. Leave blank. Not required by Medicare.

Item 16. Enter the eight-digit dates (MMDDCCYY) patient is employed and unable to work in current occupation. An entry in this field may indicate employment related insurance coverage.

Item 17. Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Referring Physician: A physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering Physician: A physician who orders non-physician services for the patient such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.

The ordering/referring requirement became effective January 1, 1992, and is required by º1833(q) of the Social Security Act. All claims for Medicare covered services and items that are the result of a physician's order or referral must include the ordering/referring physician's name and National Provider Identifier (NPI). This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- o Diagnostic laboratory services;

- o Diagnostic radiology services;

- o Consultative services; and

- o Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list must also show the ordering/referring physician's name and NPI. For example, a surgeon must complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned NPI must appear in items 17 and 17a.

All physicians who order or refer Medicare beneficiaries or services must obtain an NPI even though they may never bill Medicare directly. A physician who has not been assigned an NPI must contact the Medicare carrier.

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and NPI of the physician supervising the limited licensed practitioner must appear in items 17 and 17a.

When a patient is referred to a physician who also orders and performs a diagnostic service, a separate claim form is required for the diagnostic service.

- o Enter the original ordering/referring physician's name and NPI in items 17 and 17a of the first claim form.

o Enter the ordering (performing) physician's name and NPI in items 17 and 17a of the second claim form.

Surrogate NPIs: If the ordering/referring physician has not been assigned an NPI, one of the surrogate NPIs listed below must be used in item 17a. The surrogate NPI used depends on the circumstances and is used only until the physician is assigned an NPI. Enter the physician's name in item 17 and the surrogate NPI in item 17a. All surrogate NPIs, with the exception of retired physicians (RET00000), are temporary and may be used only until an NPI is assigned. You must monitor claims with surrogate NPIs.

The term "physician", when used within the meaning of º1861(r) of the Social Security Act, and used in connection with performing any function or action, refers to:

(1) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

(2) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions, and who is acting within the scope of his/her license when performing such functions;

(3) A doctor of podiatric medicine for purposes of subsections (k), (m), (p)(1), and (s) and ºº1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

(4) A doctor of optometry, but only with respect to the provision of items or services described in º1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

(5) A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of ºº1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist). For the purposes of º1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in º1862(a)(4) of the Act) are

furnished.

Item 17a. Enter the HCFA assigned NPI of the referring/ordering physician listed in item 17. Enter only the 7-digit base number and the 1-digit check digit.

When a claim involves multiple referring and/or ordering physicians, a separate HCFA-1500 must be used for each ordering/referring physician.

Use the following surrogate NPIs for physicians who have not been assigned individual NPIs. Claims received with surrogate numbers will be tracked and possibly audited.

- Residents who are issued an NPI in conjunction with activities outside of their residency status must use that NPI. For interns and residents without NPIs, use the eight (8) character surrogate NPI RES00000;

- Retired physicians who were not issued an NPI may use the surrogate RET00000;

- Physicians serving in the Department of Veterans Affairs or the U.S. Armed Services may use VAD00000;

- Physicians serving in the Public Health or Indian Health Services may use PHS00000;

- The law extends coverage and direct payment in non-Metropolitan Statistical Areas to practitioners who are State licensed to order medical services or refer patients to Medicare providers without the approval or collaboration of a supervising physician. Use the surrogate NPI "NPP00000" on claims involving services ordered/referred by nurse practitioners, clinical nurse specialists, or any non-physician practitioner who is State licensed to order clinical diagnostic tests; and

- When the ordering/referring physician has not been assigned an NPI and does not meet the criteria for using one of the surrogate NPIs, the biller may use the surrogate NPI "OTH00000" until an individual NPI is assigned.

Item 18. Enter the eight-digit date (MMDDCCYY) when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19. Enter the eight-digit date (MMDDCCYY) patient was last seen and the NPI of his/her attending physician when an independent physical or occupational therapist, or physician providing routine foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file. (See º2206.1.)

Enter the eight-digit X-ray date (MMDDCCYY) for chiropractor services. By entering an X-ray date, and the initiation date for course of chiropractic treatment in item 14, you are certifying that all the relevant information requirements (including level of subluxation) of the MCM, ºº2251 and 4118 are on file along with the appropriate X-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or a NOC code if one can be given within the confines of this box. Otherwise an attachment must be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See ºº2051.1 and 2070.1H respectively, for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter the eight-digit assumed and/or relinquished date (MMDDCCYY) for a global surgery claim when providers share post-operative care.

Enter the statement, "Attending physician, not hospice employee" when a physician renders services to a hospice patient but the hospice providing the patient's care (in which the patient resides) does not employ the attending physician.

Item 20. Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check
indicates that "no purchased tests are included on the claim." When "yes" is annotated, item 32 must be completed. When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form.

Item 21. Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to 4 codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for non-physician specialties must be submitted on an attachment.

Item 22. Leave blank. Not required by Medicare.

Item 23. Enter the Professional Review Organization (PRO) prior authorization number for those procedures requiring PRO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-Approved clinical trial.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number of the home health agency (HHA) or hospice when CPT code 99375 or 99376 or HCPCS code G0064, G0065, or G0066 is billed.

Enter the 10-digit CLIA (Clinical Laboratory Improvement Act) certification number for laboratory services billed by a physician office laboratory.

Enter Demonstration ID number "30" for all National Emphysema Treatment trial claims.

Item 24a. Enter the eight-digit date (MMDDCCYY) for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G.

Item 24b. Enter the appropriate place of service code(s) from the list provided in º2010.3. Identify the location, using a place of service code, for each item used or service performed.

NOTE: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

Item 24c. Medicare providers are not required to complete this item.

Item 24d. Enter the procedures, services or supplies using the HCFA Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a NOC code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.

Item 24e. Enter the diagnosis code reference number as shown in item 21, to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service; either a 1, or a 2, or a 3, or a 4.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., Pap Smears), you must reference only one of the diagnoses in item 21.

Item 24f. Enter the charge for each listed service.

Item 24g. Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

Suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems. Rounding of oxygen contents is as follows:

- For stationary gas system rentals, suppliers must indicate oxygen contents in unit

multiples of 50 cubic feet in item 24g, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen were delivered during the rental month, the unit entry "01" indicating the nearest 50 cubic foot increment is entered in item 24g.

- For stationary liquid systems, units of contents must be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10 pound increment. For example, if 63 pounds of liquid oxygen were delivered during the applicable rental month billed, the unit entry "06" is entered in item 24g.

- For units of portable contents only (i.e., no stationary gas or liquid system used) round to the nearest five feet or one liquid pound, respectively.

Item 24h. Leave blank. Not required by Medicare.

Item 24i. Leave blank. Not required by Medicare.

Items 24j and 24k. Enter the NPI of the performing provider of service/supplier if they are a member of a group practice.

NOTE: Enter the first two digits of the NPI in Item 24j. Enter the remaining six digits of the NPI in Item 24k, including the two-digit location identifier.

When several different providers of service or suppliers within a group are billing on the same HCFA-1500, show the individual NPI in the corresponding line item.

Item 25. Enter your provider of service or supplier Federal Tax I.D. (Employer Identification Number) or Social Security Number. The participating provider of service or supplier Federal Tax I.D. Number is required for a mandated Medigap transfer.

Item 26. Enter the patient's account number assigned by the provider of service's or supplier's accounting system. This field is optional to assist you in patient identification. As a service, any account numbers entered here will be returned to you.

Item 27. Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If MEDIGAP is indicated in block 9 and MEDIGAP payment authorization is given in item 13, the provider of service or supplier must also be a Medicare participating provider of service or supplier and must accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;

- Physician services to individuals dually entitled to Medicare and Medicaid;

- Participating physician/supplier services,

- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;

- Ambulatory surgical center services for covered ASC procedures; and

- Home dialysis supplies and equipment paid under Method II.

Item 28. Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29. Enter the total amount the patient paid on the covered services only.

Item 30. Leave blank. Not required by Medicare.

Item 31. Enter the signature of provider of service or supplier, or his representative, and the eight-digit date (MMDDCCYY) the form was signed.

Item 32. Enter the name and address of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. When the name and address of the facility where the services were furnished is the same as the billers name and address shown in item 33, enter the word "SAME." Providers of service (namely physicians) must identify the supplier's name, address, and NPI when billing for purchased diagnostic tests. When more than one supplier is used, a separate HCFA-1500 should be used to bill for each supplier.

This item is completed whether the supplier personnel performs the work at the physician's office or at another location.

If a QB or QU modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA), the physical location where the service was rendered must be entered if other than home. However, if the address shown in item 33 is in a HPSA and is the same as where the services were rendered, enter the word "SAME."

If the supplier is a certified mammography screening center, enter the 6 digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed and the NPI, including the 2-digit location identifier.

Item 33. Enter the provider of service/supplier's billing name, address, zip code, and telephone number.

Enter the NPI, including the 2-digit location identifier, for the performing provider of service/supplier who is not a member of a group practice.

Enter the Group NPI, including the 2-digit location identifier, for the performing provider of service/supplier who is a member of a group practice.

2010.3 Place of Service Codes (POS) and Definitions. --

New Place of Service Codes. -- The new HCFA-1500 POS codes, as well as a crosswalk to the "old" HCFA-1500 POS Codes are listed below. The current CWF POS codes are identical to those of the new HCFA-1500.

New HCFA-1500 (12/90)		Old HCFA-1500
00-10	Unassigned	
11	Office	3 - (O)
12	Home	4 - (H)
13-20	Unassigned	
21	Inpatient Hospital	1 - (IH)
22	Outpatient Hospital	2 - (OH)
23	Emergency Room - Hospital	2 - (OH)
24	Ambulatory Surgical Center	B - (ASC)
25	Birthing Center	0 - (OL)
26	Military Treatment Facility	0 - (OL)
27-30	Unassigned	
31	Skilled Nursing Facility	8 - (SNF)
32	Nursing Facility	7 - (NH)
33	Custodial Care Facility	0 - (OL)
34	Hospice	0 - (OL)
35-40	Unassigned	
41	Ambulance	Land

42	Ambulance	Air or Water
43-49	Unassigned	
50	Federally Qualified Health Center	
51	Inpatient Psychiatric Facility	0 - (OL)
52	Psychiatric Facility Partial Hospitalization	
53	Community Mental Health Center	
54	Intermediate Care Facility/ Mentally Retarded	D - (STF)
55	Residential Substance Abuse Treatment Facility	C - (RTC)
56	Psychiatric Residential Treatment Center	C - (RTC)
57-59	Unassigned	
60	Mass Immunization Center	
61	Comprehensive Inpatient Rehabilitation Facility	0 - (OL)
62	Comprehensive Outpatient Rehabilitation Facility	E - (COR)
63-64	Unassigned	
65	End-Stage Renal Disease Treatment Facility	F - (KDC)
66-70	Unassigned	
71	State or Local Public Health Clinic	0 - (OL)
72	Rural Health Clinic	0 - (OL)
73-80	Unassigned	
81	Independent Laboratory	A - (IL)
82-98	Unassigned	
99	Other Unlisted Facility	

POS Definitions.

CODES DEFINITIONS

00-10 (Unassigned)

11 Office

Location, other than a hospital, Skilled Nursing Facility (SNF), Military Treatment Facility, Community Health Center, State or Local Public Health Clinic or Intermediate Care

Facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.

12 Patient's Home

Location, other than a hospital or other facility, where the patient receives care in a private residence.

13-20 (Unassigned)

21 Inpatient Hospital

A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 Outpatient Hospital

A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23 Emergency Room - Hospital

A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 Ambulatory Surgical Center

A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

25 Birthing Center

A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery and immediate post-partum care as well as immediate care of new born infants.

26 Military Treatment Facility

A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

27-30 (Unassigned)

31 Skilled Nursing Facility

A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 Nursing Facility

A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33 Custodial Care Facility

A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 Hospice

A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

35-40 (Unassigned)

41 Ambulance-Land

A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 Ambulance Air or Water

An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

43-49 (Unassigned)

50 Federally Qualified Health Center

A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

51 Inpatient Psychiatric Facility

A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 Psychiatric Facility Partial Hospitalization

A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 Community Mental Health Center (CMHC)

A facility that provides the following services:

- Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility;

- 24 hour a day emergency care services;

- Day treatment, other partial hospitalization services, or psychosocial rehabilitation services;

- Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and

- Consultation and education services.

54 Intermediate Care Facility/Mentally Retarded

A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55 Residential Substance Abuse Treatment Facility

A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 Psychiatric Residential Treatment Center

A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57-59 (Unassigned)

60 Mass Immunization Center

A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting. (See º4408.8.)

61 Comprehensive Inpatient Rehabilitation Facility

A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 Comprehensive Outpatient Rehabilitation Facility

A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

63-64 (Unassigned)

65 End Stage Renal Disease Treatment Facility

A facility other than a hospital, which provides dialysis treatment, maintenance and/or training to patients or care givers on an ambulatory or home-care basis.

66-70 (Unassigned)

71 State or Local Public Health Clinic

A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

72 Rural Health Clinic

A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

73-80 (Unassigned)

81 Independent Laboratory

A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

82-98 (Unassigned)

99 Other Unlisted Facility

Other service facilities not identified above.

2010.4 Exhibits. --

- Exhibit 1 - Health Insurance Claim Form HCFA-1500;

- Exhibit 2 - User Print File Matrix;

- Exhibit 3 - User Print File Specifications;

- Exhibit 4 - Printing Standards - A revision of form HCFA-1500 Specifications first issued by GPO for distribution with the negatives. These include the original HCFA-1500 (12/90) Printing Standards given to the GPO; and

- Exhibit 5 - Printing Overlay Standards - Includes registration marks, forms identification, provider identification, and other overlay (second color) information that may be preprinted within the body of the form or in the white space at the top of the form. It may also include the bar codes used by some carriers.

Exhibit - 1

PAGE RESERVED FOR

HEALTH INSURANCE CLAIM FORM (FORM HCFA-1500)

Exhibit 1 (Cont.)

PAGE RESERVED FOR

CONTINUATION OF

HEALTH INSURANCE CLAIM FORM

Rev. 8 2-272010.4 (Cont.)HEALTH INSURANCE CLAIM FORM -- HCFA-1500

Exhibit - 2

PAGE RESERVED FOR

User Print File Matrix

Exhibit - 3

User Print File Specifications

LINE	FIELD	LITERAL	FIELD TYPE*	BYTES	COLUMNS
1	Left printer alignment block	M301-03			
1	Right printer alignment block		M	3	76-78
3	1 Medicare		M	1	01
3	1 Medicaid		M	1	08
3	1 Champus		M	1	15
3	1 Champva		M	1	24
3	1 Group Health Plan		M	1	31
3	1 FECA Blk Lung		M	1	39
3	1 Other		M	1	45
3	1a	Insured's ID Number	A/N	29	50-78
5	2 Patient's Name (Last, First, MI)		A	29	01-29
5	3 Patient's Birth Date (Month)		N	2	31-32
5	3 Patient's Birth Date (Day)		N	2	33-34
5	3 Patient's Birth (Year)		N	4	35-38
5	3 Sex-Male		A	1	42

5	3 Sex-Female	A	1	47	
5	4 Insured Name (Last, First, MI)	A	29	50-78	
7	5 Patient's Address (No., Street)	A/N	29	01-29	
7	6 Patient Relationship to Insured (Self)	M	1	33	
7	6 Patient Relationship to Insured (Spouse)	M	1	38	
7	6 Patient Relationship to Insured (Child)	M	1	42	
7	6 Patient Relationship to Insured (Other)	M	1	47	
7	7 Insured's Address (No., Street)	A/N	29	50-78	
9	5 Patient's Address (City)	A	24	01-24	
9	5 Patient's Address (State)	A	2	26-27	
9	8 Patient Status (Single)	M	1	35	
9	8 Patient Status (Married)	M	1	41	
9	8 Patient Status (OTher)	M	1	47	
9	7 Insured's Address (City)	A	23	50-72	
9	7 Insured's Address (State)	A	2	74-75	

Rev. 13 2-292010.4 (Cont.)HEALTH INSURANCE CLAIM FORM - HCFA-1500

LINE	FIELD	LITERAL TYPE*	FIELD	BYTES	COLUMNS
11	5 Patient's Address (Zip Code)	N	9	01-09	
11	5 Patient's Area Code	N	3	15-17	
11	5 Patient's Phone #	N	7	19-25	

11	8 Patient Status (Employed)	M	1	35	
11	8 Patient Status (Full Time Student)	M	1	41	
11	8 Patient Status (Part Time Student)	M	1	47	
11	7 Insured's Address (Zip Code)	N	9	50-58	
11	7 Insured's Area Code	N	3	65-67	
11	7 Insured's Phone #	N	7	69-75	
13	9 Other Insured's Name (Last, First, MI)	A	29	01-29	
13	11	Insured's Policy, Group or FECA Number	A/N	29	50-78
15	9a	Other Insured's Policy or Group Number	A/N	29	01-29
15	10a	Condition Related (Employment C/P, Yes)	M	1	35
15	10a	Condition Related (Employment C/P, No)	M	1	41
15	11a	Insured's Date of Birth (Month)	N	2	54-55
15	11a	Insured's Date of Birth (Day)	N	2	57-58
15	11a	Insured's Date of Birth (Year)	N	4	60-63
15	11a	Sex-Male	M	1	68
15	11a	Sex-Female	M	1	75
17	9b	Other Insured's Date of Birth (Month)	N	2	02-03
17	9b	Other Insured's Date of Birth (Day)	N	2	05-06
17	9b	Other Insured's Date of Birth (Year)	N	4	08-11
17	9b	Sex-Male	M	1	18
17	9b	Sex-Female	M	1	24
17	10b	Condition Related (Auto Accident-Yes)	M	1	35
17	10b	Condition Related (Auto Accident-No)	M	1	41

17	10b	Condition Related (Place-State)	A	2	46-47
17	11b	Insured's Employer's Name or School Name	A	29	50-78
19	9c	Other Insured's Employer's Name or School	A/N	29	01-29
19	10c	Other Accident (Yes)	M	1	35
19	10c	Other Accident (No)	M	1	41
19	11c	Insured's Insurance Plan or PayerID	A/N	29	50-78

LINE	FIELD	LITERAL	FIELD TYPE*	BYTES	COLUMNS
21	9d	Other Insured's Insurance Plan Name or PayerID	A/N	29	01-29
21	10d	Condition Relate (Reserved for Local Use)	A/N	18	31-48
21	11d	Another Benefit Health Plan (Yes)	M	1	52
21	11d	Another Benefit Health Plan (No)	M	1	57
25	12	Left Blank for Patient's Signature			
25	13	Left Blank for Insured's Signature			
27	14	Date of Current Illness, Injury, Pregnancy (Month)	N	2	02-03
27	14	Date of Current Illness, Injury, Pregnancy (Day)	N	2	05-06
27	14	Date of Current Illness, Injury, Pregnancy (Year)	N	4	08-11
27	15	First Date Has Had Same or Similar Illness (Month)	N	2	

37-38

27 15 First Date Has Had Same or Similar Illness (Day) N 2
40-41

27 15 First Date Has Had Same or Similar Illness (Year) N 4
43-46

27 16 Dates Patient Unable to Work (From Month) N 2 54-55

27 16 Dates Patient Unable to Work (From Day) N 2 57-58

27 16 Dates Patient Unable to Work (From Year) N 4 60-63

27 16 Dates Patient Unable to Work (To Month) N 2 68-69

27 16 Dates Patient Unable to Work (To Day) N 2 71-72

27 16 Dates Patient Unable to Work (To Year) N 4 74-77

29 17 Name of Referring Physician or Other Source A 26 01-26

29 17a NPI Number of Referring Physician A/N 21 28-48

29 18 Hospitalization Related Current Svcs (From Month) N 2
54-55

29 18 Hospitalization Related Current Svcs (From Day) N 2
57-58

29 18 Hospitalization Related Current Svcs (From Year) N 4
60-63

29 18 Hospitalization Related Current Svcs (To Month) N 2
68-69

29 18 Hospitalization Related Current Svcs (To Day) N 2 71-72

29 18 Hospitalization Related Current Svcs (To Year) N 4 74-77

31 19 Reserved for Local Use A/N 48 01-48

31 20 Outside Lab (Yes) M 1 52

31 20 Outside Lab (No) M 1 57

31	20	$ Charges	N	7	62-68
33	21.1	Diagnosis or Nature of Illness or Injury (Code)	N	3	03-05

LINE	FIELD	LITERAL	FIELD TYPE*	BYTES	COLUMNS
33	21.1	Diagnosis or Nature of Illness or Injury (Code)	N	2	07-08
33	21.1	Diagnosis	A	20	10-29
33	21.3	Diagnosis or Nature of Illness or Injury (Code)	N	3	31-33
33	21.3	Diagnosis or Nature of Illness or Injury (Code)	N	2	35-36
33	21.3	Diagnosis	A	11	38-48
33	22	Medicaid Resubmission Code	N	8	53-60
33	22.2	Original Reference Number	N	13	66-78
35	21.2	Diagnosis or Nature of Illness or Injury (Code)	N	3	03-05
35	21.2	Diagnosis or Nature of Illness or Injury (Code)	N	2	07-08
35	21.2	Diagnosis	A	20	10-29
35	21.4	Diagnosis or Nature of Illness or Injury (Code)	N	3	31-33
35	21.4	Diagnosis or Nature of Illness or Injury (Code)	N	2	35-36
35	21.4	Diagnosis	N	11	38-48
35	23	Prior Authorization Number	A/N	29	50-78
39	24.1a	Date(s) of Service (From Month)	N	2	01-02
39	24.1a	Date(s) of Service (From Day)	N	2	03-04

39	24.1a	Date(s) of Service (From Year)	N	4	05-08
39	24.1a	Date(s) of Service (To Month)	N	2	10-11
39	24.1a	Date(s) of Service (To Day)	N	2	12-13
39	24.1a	Date(s) of Service (To Year)	N	4	14-17
39	24.1b	Place of Service	A/N	2	19-20
39	24.1c	Type of Service	A/N	2	22-23
39	24.1b	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	5	26-30
39	24.1c	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
39	24.1c	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
39	24.1e	Diagnosis Code	A/N	6	42-47
39	24.1f	$ Charges	N	5	50-54
39	24.1f	$ Charges	N	2	56-57
39	24.1g	Days or Units	N	3	59-61
39	24.1h	EPSDT Family Plan	A/N	2	62-63
39	24.1i	EMG	A/N	2	65-66
39	24.1j	COB	A/N	2	68-69

LINE	FIELD	LITERAL	FIELD TYPE*	BYTES	COLUMNS
39	24.1k	Reserved for Local Use	A/N	8	70-77
41	24.2a	Dates of Service (From Month)	N	2	01-02

41	24.2a	Dates of Service (From Day)	N	2	03-04
41	24.2a	Dates of Service (From Year)	N	4	05-08
41	24.2a	Dates of Service (To Month)	N	2	10-11
41	24.2a	Dates of Service (To Day)	N	2	12-13
41	24.2a	Dates of Service (To Year)	N	4	14-17
41	24.2b	Place of Service	A/N	2	19-20
41	24.2c	Type of Service	A/N	2	22-23
41	24.2d	Procedures, Scvs or Supplies (CPT/HCPCS)	A/N	5	26-30
41	24.2d	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
41	24.2d	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
41	24.2e	Diagnosis Code	A/N	6	42-47
41	24.2f	$ Charges	N	5	50-54
41	24.2f	$ Charges	N	2	56-57
41	24.2g	Days or Units	N	3	59-61
41	24.2h	EPSDT Family Plan	A/N	2	62-63
41	24.2i	EMG	A/N	2	65-66
41	24.2j	COB	A/N	2	68-69
41	24.2k	Reserved for Local Use	A/N	8	70-77
43	24.3a	Dates of Service (From Month)	N	2	01-02
43	24.3a	Dates of Service (From Day)	N	2	03-04
43	24.3a	Dates of Service (From Year)	N	4	05-08
43	24.3a	Dates of Service (To Month)	N	2	10-11
43	24.3a	Dates of Service (To Day)	N	2	12-13

43	24.3a	Dates of Service (To Year)	N	4	14-17
43	24.3b	Place of Service	A/N	2	19-20
43	24.3c	Type of Service	A/N	2	22-23
43	24.3d	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	5	26-30
43	24.3d	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
43	24.3d	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
43	24.3e	Diagnosis Code	A/N	6	42-47

LINE	FIELD	LITERAL	FIELD TYPE*	BYTES	COLUMNS
43	24.3f	$ Charges	N	5	50-54
43	24.3f	$ Charges	N	2	56-57
43	24.3g	Days or Units	N	3	59-61
43	24.3h	EPSDT Family Plan	A/N	2	62-63
43	24.3i	EMG	A/N	2	65-66
43	24.3j	COB	A/N	2	68-69
43	24.3k	Reserved for Local Use	A/N	8	70-77
45	24.4a	Dates of Service (From Month)	N	2	01-02
45	24.4a	Dates of Service (From Day)	N	2	03-04
45	24.4a	Dates of Service (From Year)	N	4	05-08
45	24.4a	Dates of Service (To Month)	N	2	10-11

45	24.4a	Dates of Service (To Day)	N	2	12-13
45	24.4a	Dates of Service (To Year)	N	4	14-17
45	24.4b	Place of Service	A/N	2	19-20
45	24.4c	Type of Service	A/N	2	22-23
45	24.4d	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	5	26-30
45	24.4d	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
45	24.4d	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
45	24.4e	Diagnosis Code	A/N	6	42-47
45	24.4f	$ Charges	N	5	50-54
45	24.4f	$ Charges	N	2	56-57
45	24.4g	Days or Units	N	3	59-61
45	24.4h	EPSDT Family Plan	A/N	2	62-63
45	24.4i	EMG	A/N	2	65-66
45	24.4j	COB	A/N	2	68-69
45	24.4k	Reserved for Local Use	A/N	8	70-77
47	24.5a	Dates of Service (From Month)	N	2	01-02
47	24.5a	Dates of Service (From Day)	N	2	03-04
47	24.5a	Dates of Service (From Year)	N	4	05-08
47	24.5a	Dates of Service (To Month)	N	2	10-11
47	24.5a	Dates of Service (To Day)	N	2	12-13
47	24.5a	Dates of Service (To Year)	N	4	14-17

LINE	FIELD	LITERAL	FIELD TYPE*	BYTES	COLUMNS
47	24.5b	Place of Service	A/N	2	19-20
47	24.5c	Type of Service	A/N	2	22-23
47	24.5d	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	5	26-30
47	24.5d	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
47	24.5d	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
47	24.5e	Diagnosis Code	A/N	6	42-47
47	24.5f	$ Charges	N	5	50-54
47	24.5f	$ Charges	N	2	56-57
47	24.5g	Days or Units	N	3	59-61
47	24.5h	EPSDT Family Plan	A/N	2	62-63
47	24.5i	EMG	A/N	2	65-66
47	24.5jCOBA/N				268-69
47	24.5k	Reserved for Local Use	A/N	8	70-77
49	24.6a	Dates of Service (From Month)	N	2	01-02
49	24.6a	Dates of Service (From Day)	N	2	03-04
49	24.6a	Dates of Service (From Year)	N	4	05-08
49	24.6a	Dates of Service (To Month)	N	2	10-11
49	24.6a	Dates of Service (To Day)	N	2	12-13
49	24.6a	Dates of Service (To Year)	N	4	14-17

49	24.6b	Place of Service	A/N	2	19-20
49	24.6c	Type of Service	A/N	2	22-23
49	24.6d	Procedures, Svcs or Supplies (CPT/HCPCS)	A/N	5	26-30
49	24.6d	Procedures, Svcs or Supplies (Modifier)	A/N	2	32-33
49	24.6d	Procedures, Svcs or Supplies (Modifier)	A/N	5	35-39
49	24.6e	Diagnosis Code	A/N	6	42-47
49	24.6f	$ Charges	N	5	50-54
49	24.6f	$ Charges	N	2	56-57
49	24.6g	Days or Units	N	3	59-61
49	24.6h	EPSDT Family Plan	A/N	2	62-63
49	24.6i	EMG	A/N	2	65-66
49	24.6j	COB	A/N	2	68-69
49	24.6k	Reserved for Local Use	A/N	8	70-77

LINE	FIELD	LITERAL	FIELD TYPE*	BYTES	COLUMNS
51	25	Federal Tax ID Number	N	15	1-15
51	25	Federal Tax ID Number (SSN)	M	1	17
51	25	Federal Tax ID Number (EIN)	M	1	19
51	26	Patient's Account Number	A/N	14	23-36
51	27	Accept Assignment (Yes)	M	1	38

51	27	Accept Assignment (No)	M	1	43
51	28	Total Charge (Dollars)	N	6	51-56
51	28	Total Charge (Cents)	N	2	58-59
51	29	Amount Paid (Dollars)	N	5	62-66
51	29	Amount Paid (Cents)	N	2	68-69
51	30	Balance Due (Dollars)	N	5	71-75
51	30	Balance Due (Cents)	N	2	77-78
53	32	Name of Facility Where Svcs Rendered	A/N	25	23-47
53	33	Physician/Supplier Billing Name	A/N	29	50-78
54	32	Address of Facility Where Svcs Rendered	A/N	25	23-47
54	33	Physician/Supplier Address	A/N	29	50-78
55	31	Left Blank for Signature Physician/Supplier			
55	32	Address of Facility Where Svcs Rendered	A/N	25	23-47
55	33	Zip Code/Phone # of Physician/Supplier	A/N	29	50-78
5532	Address of Facility Where Svcs Rendered	A/N	25	23-47	
56	33	Provider of Service/Supplier NPI Number	A/N	10	52-61
56	33	Provider of Service/Supplier GRP NPI Number	A/N	10	67-78

* M = mark (X), A = alpha, N = numeric

Exhibit - 4

Printing Standards

The HCFA-1500 (12-90) is designed to accommodate 10-pitch Pica type, 6 lines per inch. Once adjusted to the left and right, PICA alignment blocks in the first print line and characters appear within form lines as shown in the print file matrix.

Also, provided on the HCFA-1500 (12-90) is a typewriter alignment bar. This is the thick horizontal line that is at the base of the PICA alignment boxes.

The HCFA-1500 (12-90) is used in four different styles. Any one of these four styles may be printed from two negatives provided by the US Government Printing Office. (GPO) The face negative furnished must be used for Parts 1 and 2. The back negative furnished must be used for Part 1 only.

The Printing Standards in Exhibit 4 are used in conjunction with the negatives provided by GPO. Compliance with these standards is required to facilitate the use of image processing technology such as Optical Character Recognition, facsimile transmission, and image storage.

Checks or money orders for the purchase of the negatives from the US GPO are to be made payable to the Public Printer and sent to:

Asst. Supt., Dept. of Acct., Rep. Div.
USGPO Room
Room C-830
Washington DC 20401

or call (202) 512-1800.

Cut Sheet:

Size - 8 1/2 inches (plus or minus 0.1 inch) by 11 inches (plus or minus 1/6 inch). 217mm by 281mm plus or minus 2mm.

Print- Face and back, head to head.

Margins:

Face-The top margin from the top edge of the form to the typewriter alignment bar is 1 1/3 inches or 34mm. The left margin is 0.3 inch to the left end of the typewriter alignment bar.

Back-0.25 inch head and foot,
0.25 inch left and right.

Offset-The X and Y offset for margins must not vary by more than +/- 0.1 inch from sheet to sheet.

The X offset refers to the horizontal distance from the left edge of the paper to the beginning of the printing. The Y offset refers to the vertical distance between the top of the paper and the beginning of the printing.

Askewity- The askewity of the printed image must be no greater than 0.15mm in 100mm.

Stock- White, OCR Bond, 20 lbs., equal to JCP-O-25. Cut square with each corner 90 degrees, plus or minus 0.025 degrees.

Ink Color:
Face-Sinclair Valentine J6983, OCR red or equal.
Back-Same as face.

Two Part Snapset:

Size - Same dimensions as for Cut Sheet (detached 8.5" by 11"), plus top stub (0.5" - 0.75").

Print:

Part 1 -Face and back, head to head.

Part 2 -Face only. (Instructions print on the back of Part 1 only.)

Margins- Same as for Cut Sheet.

Askewity- Same as for Cut Sheet.

Stock:

Part 1 -Same as for Cut Sheet.

Part 2 -Any color or weight that will not interfere with scanning of the Part 1 sheet.

Ink Color:

Part 1 -Same as for Cut Sheet.

Part 2 -Any color that will not interfere with scanning of the Part 1 sheet.

Perforations- Perforate top stub along 8.5" X dimension for disassembly of parts. Do not perforate carbons.

Carbon- Black one time of sufficient quality to ensure legibility of Part 2. To extend to within 0.5" of bottom of detached sheet. Carbon impression must be clear and sharp without smearing or smudging.

One Part Marginally Punched Continuous Form:

Size- Same dimensions as for Cut Sheet, plus 0.5" left and right, (Overall: 9.5" by 11", detached: 8.5" by 11").

Print- Face and back, head to head.

Margins- On detached sheet, same as for Cut Sheet.

Askewity- On detached sheet, same as for Cut Sheet.

Stock- Same as for Cut Sheet.

Ink Color- Same as for Cut Sheet.

Perforations- Marginally 1/2" left and right, tearline horizontally every 11".

Two Part Marginally Punched Continuous Form:

Size- Same dimensions as for Cut Sheet, plus 1/2" left and right, (overall: 9.5" x 11", detached: 8.5" x 11").

Print:

Part 1 -Face and back, head to head.

Part 2 -Face only, head to head (Instructions print on the back of Part 1 only.)

Margins- On detached sheet, same as for Cut Sheet.

Askewity- On detached sheet, same as for Cut Sheet.

Stock:

Part 1 -Same as for Cut Sheet.

Part 2 -Any color or weight that does not interfere with scanning of the Part 1 sheet.

Ink Color:

Part 1 -Same as for Cut Sheet.

Part 2 -Any color that will not interfere with scanning of the Part 1 sheet.

Perforations- Marginally 1/2" left and right, tearline horizontally every 11".

Carbon- Black one time of sufficient quality to ensure legibility of Part 2. To extend to within 1/2" of bottom of detached sheet. Carbon impression must be clear and sharp without smearing or smudging.

Joining- Crimp left and right

Exhibit - 5

Printing Overlay Standards

No modification is to be made to the HCFA-1500 (12/90) without prior approval of the Health Care Financing Administration.

Second color overlays (other than red) may be printed on the form if they comply with the following specifications:

Registration Lines:
One inch perpendicular lines on the corners of body of form. Other registration methods (e.g., cornerstones) will be considered for approval.

Form Identification:
Bottom left of form contains the OMB approval number (APPROVED OMB-0938-0008). A quick scan determines which forms definition to use for the rest of the scan.

The carrier name and address areas and white space in the upper right of the form and above the bar code may be used for a form identifier. Standard fonts (such as OCR-B), bar codes, and other widely recognized formats will be considered for approval.

Bar Codes:
The left side of the top portion of the form, within the area designated "CARRIER", may be used to designate a place for a unique bar code. The application must start no less than 30mm from the left edge of the Cut Sheet, and no more than 90mm from the same left edge and extend no lower than 2mm above the typewriter alignment bar.

Carrier Name and Address:
The right side of the top portion of the form, within the area designated "CARRIER", may be used by the carrier for printing customized names and addresses, and/or imprinting document control numbers. The area must be limited to extend no lower than 2mm above the label "HEALTH INSURANCE CLAIM FORM".

Printer Identification:
Printers' names must appear in the bottom margin, starting below the left vertical line of the cut sheet. A small logo may appear with the name.

ITEM 33:

When using 10 pitch PICA type, item 33 contains room for 3 lines of 29 characters each, plus room for a provider of service/supplier NPI # of 10 positions and a GRP NPI # of 10 positions. Normally, name, street address, city and state, and ZIP and phone number require at least 4 lines.

The five-digit ZIP code provides enough information to identify both city and state; in some cases, the nine-digit ZIP code can also replace the street address.

Line 1:Physician/Suppliers billing name.
Line 2:Street Address with City and State, if room.
Line 3:positions 1-11:
9 digit ZIP code with hyphen,
positions 14-29:
10 digit phone number with hyphens and extension.

Example:

Line 1_Dr. Jonas Salk
Line 2_7500 Security Blvd Balto MD
Line 321208-8888 410-555-9999x1234
Line 4__XNPI79xxxx_____GROUPNPINUMBER9